CASE MANAGEMENT
SERVICE PLAN ADDENDUM
☐ **THSteps MCM** ☐ **TCM/PWI** ☐ **CSHCN**

Name: _____ DOB: _____ Medicaid#: _____

Service need:

ACTION PLAN	BY WHOM	BY WHEN	DATE RESOLVED/ INITIALS

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ACTION PLAN	BY WHOM	BY WHEN	DATE RESOLVED/ INITIALS

Copy of SP addendum provided to client/parent/guardian: ☐ Yes ☐ No

Client/parent/guardian gives consent for the case manager to send a copy of this service plan addendum to:
☐ Primary Care Provider (PCP) ☐ Referral Source ☐ Other, specify: _____.
☐ Client refuses consent to forward SP ☐ N/A for TCM/PWI Clients

I am a: ☐ client ☐ parent ☐ guardian. I know that within the Medicaid guidelines, I have freedom of choice for medical, dental, and case management services as needed. I know that, within the Medicaid guidelines, I have freedom of choice for equipment and supplies as needed. I took part in the making of this service plan. I understand that the referrals listed above will help put this plan into effect. I understand the referrals will be made on my behalf (or my child's). I understand that information from my needs assessment may be needed to help with referrals in the plan. I give my consent for my case manager to share the information as needed to help with the referrals. I understand that the information will be shared only with agencies listed in the plan. The information shared will be only what is needed to complete the referral, determine eligibility, or provide services to my childor to me. This consent will expire when the above needs have been met. I understand that I may take back or cancel this consent anytime. To cancel it, I must write to my case manager. I understand that this consent will not affect my (or my child's) treatment, payment, enrollment, or eligibility for benefits. I understand that anyone who gets information as a result of this consent may share it with others as the law allows.

Client/Parent Guardian Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

Case Management Provider/Agency Name _____ Phone: ( ) -

Case Management Provider Address _____

Interpreter Signature (if applicable): _____ Date: _____